EMERGENCY MEDICAL SERVICES FAX FOR REPORTING COMPLAINTS

GENERAL INSTRUCTIONS:

These instructions apply to reporting complaints and other concerns about either licensed ambulance services or emergency medical technicians. They also govern the reporting of suspected abuse, neglect, mistreatment and misappropriation of patient property in nursing homes, rest homes, home health and homemaker agencies, and hospices, under the Patient Abuse Law.

1. Complete a separate blank form for each occurrence following the instructions below.

2. Use the attached tables to enter a description for those items that are marked "see table."

3. Submit your completed report by fax to the Department immediately for suspected abuse, neglect, mistreatment or misappropriation involving nursing home, rest home, home health, homemaker and hospice patients. **Notify the Department immediately by phone at 617-753-8150 of any deaths suspected as resulting from abuse or neglect**. Submit other completed reports within five days of the date of the occurrence.

4. Fax your completed report to the Department at **617-753-8165**.

LINE BY LINE INSTRUCTIONS

PAGE 1 OF REPORT FORM:

FROM: Please provide the name and address of the service making the report.

DATE OF REPORT: Enter the date that you are submitting your report to the Department.

FOR ABUSE, NEGLECT, MISTREATMENT or MISAPPROPRIATION OCCURING IN NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER OR HOSPICE SETTING:

FACILITY/AGENCY NAME: Indicate the name of the provider at which the suspected abuse, neglect, mistreatment or misappropriation occurred.

ADDRESS: Indicate the address (city or town, if street address is not known) of the provider at which the suspected abuse, neglect or misappropriation occurred.

GENERAL INFORMATION: Please indicate your name and title, as the person preparing this report, a phone number at which we can contact you if we need additional information; the date, time and place of the occurrence; and the involved vehicle's DPH assigned Ambulance Service Number. If you are not able to determine when the event occurred, state "unknown".

PATIENT INFORMATION: Please provide information here regarding the patient involved. If more than one patient was injured, provide additional patient information under the narrative portion of the report or on an additional page. Please indicate:

NAME: The patient's first and last name.

AGE; SEX: Enter each for the named patient.

MENTALLY RETARDED/DEVELOPMENTALLY DISABLED: Indicate whether or not the patient is mentally retarded or developmentally disabled. If the resident is either, indicate the name of the Service Coordinator (mentally retarded) or Case Manager (developmentally disabled) assigned to the patient, if known.

REPORT DETAIL:

OCCURRENCE TYPE: Select the term from Table #1, "Occurrence Type", that best describes the occurrence you are reporting. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

TYPE OF HARM: Select the term from Table #2, "Type of Harm", that best describes the harm or injury that resulted from the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report. Note that harm includes psychological injury as well as physical harm, and SHOULD NOT BE DESCRIBED AS "NONE" SIMPLY BECAUSE THERE WAS NO PHYSICAL HARM.

BODY PART AFFECTED: Use terms such as "arm", "foot", etc.; indicate left or right when it applies.

WHAT EQUIPMENT, IF ANY, WAS BEING USED AT TIME OF OCCURRENCE: Specify if any equipment was in use, such as "defibrillator".

PAGE 2 OF REPORT FORM:

NARRATIVE: Describe fully what occurred. Indicate who, what, when, where, why and how what is being reported occurred. Include information on how any person injured was treated. If there were any unusual circumstances involved, describe these fully.

CORRECTIVE MEASURES NARRATIVE: Describe what actions have been taken in response to the occurrence.

NOTIFICATION: Indicate whether or not other individuals or agencies have been notified of this occurrence, and if so who.

WITNESS INFORMATION: List the name and telephone number (if known) for individuals who saw or heard what occurred. Indicate if any of witnesses were directly involved in

what occurred. If the name of a witness is unknown, indicate any in the narrative any information known about the witnesses.

LINE BY LINE INSTRUCTIONS - CONTINUED

ACCUSED INFORMATION: When reporting suspected abuse, neglect or misappropriation, or allegations involving the conduct or qualifications of a specific EMT, indicate the name of the EMT, a phone number at which the EMT can be contacted, and the EMT's registration number. Check the appropriate block if you are not reporting abuse or other allegations against an individual, or the identity of the person(s) suspected of abuse, neglect or misappropriation of a patient's money or belongings is unknown. If more than one individual is suspected, indicate on an additional sheet the other individual's names, a phone number at which they may be contacted, and if any person was acting as a nurse aide, home health aide or homemaker.

REPORTING TABLES:

Table #1: Occurrence Type

Abuse
Neglect
Misappropriation
Quality of Care
Delay in Care or Access to Service
Medication Error
Unprofessional Behavior
Criminal Act
Pending Strike
Equipment Failure/Malfunction - Communications
Equipment Failure/Malfunction - Medical
Fire
Theft of Ambulance
Motor Vehicle Crash
Serious injury to a patient (other - describe)
Other(Describe)

Table #2: Type of Harm:

Fracture
Laceration
Bruise/Hematoma
Reddened Area
Dislocation
Burn
Unwelcome Sexual Contact/Advance
Emotional Harm/Upset
Care Not Provided
Quality of Care
Decline in Condition
Infection
Confinement
Property
Funds
Death
No Harm
Other(Describe)

EMS PROVIDER FAX REPORT FORM

TO: INTAKE STAFF
DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH CARE QUALITY
FAX NUMBER: 617-753-8165

FROM: Ambulance Services or EMS Provider:_____
Address (Street): _____
Address (City/Town) _____

DATE OF REPORT: _____ NUMBER OF PAGES: _____

IF ABUSE, NEGLECT, or MISAPPROPRIATION OCCURING IN *NURSING HOME, REST HOME, HOME HEALTH OR HOSPICE SETTING:*
ABOUT: Facility/Agency Name: _____
Address: _____

GENERAL INFORMATION:
Report prepared by: _____
Title: _____
Phone Number: (_____)_____-_____Ext:_____
Date of Occurrence: Month_____ Date_____ Year_____
Time of Occurrence: _____ am_____ pm_____
Place of Occurrence: City/Town _____
Address _____
Vehicle Service Number: _____

PATIENT INFORMATION:
Name: First _____ Last_____
Age: _____
Sex: Male _____ Female _____
Mentally Retarded/Developmentally Disabled: ____ Yes ____No.
If yes, Service Coordinator or Case Manager (if known): _____

REPORT DETAIL:
Occurrence Type (See table #1):_____
Type of Harm (See table #2):_____
Body Part Affected: _____ L:____ R: ____
What equipment, if any, was being
used at time of occurrence? _____

[Form continues to page 2.]

NARRATIVE: (Please address the following: What happened? What factors contributed to the occurrence? Any relevant information which establishes cause? Have there been similar incidents in the past? How were the injuries treated? [Attach additional pages as needed.])

Were there any unusual circumstances involved? Yes_____ No_____ If yes, please describe. [Attach additional pages as needed.]

CORRECTIVE MEASURES NARRATIVE: N/A - Incident occurred with another provider _____. (Please address the following: Was there an internal investigation: Yes_____ No_____ If No - why? If yes- What are the investigation findings? What action was taken with regard to: Patient?; Staff?; Service practice? What is the patient's current status? What corrective action taken regarding equipment involved, if applicable? [Attach additional pages as needed.])

NOTIFICATION: Have or will any other agencies or entities be notified of this incident.
Yes_____ No_____ If yes:

Name: _____
Agency: _____
Telephone #: _____

WITNESS INFORMATION: (Check here if unwitnessed: _____)

Name:	Telephone #:	Directly Involved:
_____	(___)____-_____	YES____NO_____
_____	(___)____-_____	YES____NO_____

ACCUSED INFORMATION: (Check here if unknown or not applicable: _____)

Name #1: Telephone #:
_____(____)____-_____ EMT: YES ____ NO _____
If yes, indicate license #:_____ and level of function: _____

Name #2: Telephone #:
_____(____)____-_____ EMT: YES ____ NO _____
If yes, indicate license #:_____ and level of function: _____

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